Decentralised health care in Canada

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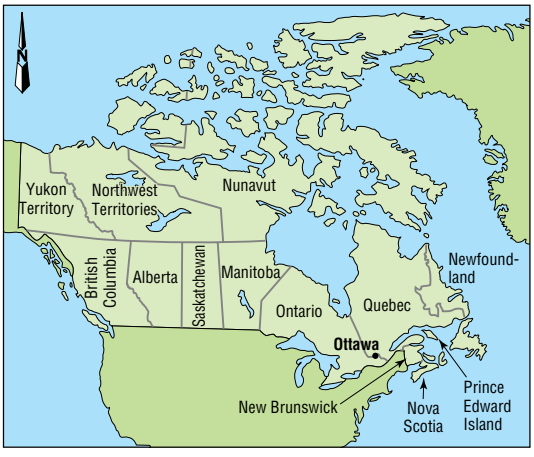
An indicator of the size of Canada is that St John's, Newfoundland, is equidistant from Moscow and Dawson City, Yukon. Yet Canada has a population of just over 30 million. Its 10 provinces vary in population from tiny Prince Edward Island with under 140 000 inhabitants to Ontario with well over 11 million. Its three territories together have barely 100 000 residents spread over 3.9 million square kilometres of land.

It is no surprise, then, that since its inception the Canadian public healthcare system has been decentralised. Since Canada became a nation in 1867, health care has been primarily a responsibility of the provinces. They have strongly defended their rights, and have often been supported by private insurers and providers in their resistance to a national health system. Yet the 1937 Royal Commission on Dominion-Provincial Relations emphasised the chaotic financial results on business if some provinces, acting independently on health insurance, levied taxes on employers that placed them in a less competitive position with respect to business in provinces that did not.[1] Thus, when a public healthcare system became a top priority after the second world war, planners sought to balance local control with the need for some degree of uniformity throughout Canada, and therefore in the collection of tax contributions by the federal government.

The federal government, unable to achieve federal-provincial consensus, used its spending power to bring provinces into a national plan. The strategy was simple. Making an offer no province could resist, the federal government promised to pay half the costs of hospitals and, later, of doctors' services, as long as the provinces conformed to some basic principles. These two initiatives were later brought together, and the principles made more explicit, in the 1984 Canada Health Act.[2] The five principles of the act (box) are mutually reinforcing, in ways that are designed to ensure reasonable equity, access and conditions.



Since Canada became a nation in 1867, health care has been primarily the responsibility of the provinces

Summary points

Canada's public healthcare system has been decentralised since its inception; it is primarily the responsibility of the provinces

"Reforms" to limit hospital stays mean privatisation and the loss of the protection enjoyed by Canadians under the provisions of the Canada Health Act

For-profit companies are now moving into the system, often from the United States

Strengths in the system

Adherence to the principles has helped ensure both choice and equitable treatment for patients, providers, and employers. Supplemented by federal equalisation payments to the poorer provinces, it has also promoted equity among provinces that vary enormously in population and wealth, while providing them with enough flexibility to develop their own ways of delivering care. As shown in the table, all provinces spend about the same amount per capita on health care, and the richest provinces (Alberta, Ontario, and British Columbia) do not necessarily spend the most. The rich provinces do slightly better than the others in terms of life expectancy, but not necessarily by other health measures.

Basically, the Canadian medicare system provides public payment for private practice and private provision. The federal and provincial governments pay, but much of the provision is left to those who delivered care before the public system was introduced. The main difference is that, under the public system, almost all the hospital and doctors' bills go to the provinces. With its contribution to health care clearly defined, the federal government could and did withhold money from any province contravening the principles of the Canada Health Act. Similarly, provinces controlled hospitals through negotiated budget allocations while setting standards for care. Hospitals were run mainly by locally appointed boards, and doctors were the main gatekeepers to the system, with the doctors guaranteed payment under a negotiated fee for service system. This left doctors, patients, and hospitals with a wide range of choices, especially in urban settings.

Tensions and weaknesses

Payment schemes

The payment schemes that contributed to provincial, hospital, and doctor control also made it difficult to estimate or limit expenditures. Although "the period of the most rapid escalation *ended* with the establishment of universal coverage"[5] in 1971, the federal government soon became concerned about writing blank cheques to

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The five principles of the Canada Health Act

- **Portability**: Citizens are eligible for coverage in all provinces. This means that employees can follow job opportunities both within and between provinces, without losing their coverage and without restricting flexibility of the labour force. Because residents are signed up to a provincial plan, they can access care anywhere in the province. The portability requirement also means that provinces without the resources to provide very specialised treatments can purchase them in other parts of the country, ensuring coverage for their citizens while efficiently using resources.
- **Public administration** enables governments to distribute services more effectively and efficiently, and with more stability. It allows for public debate and planning; integration and continuity are also more readily achieved with public administration. Private insurance is implicitly or explicitly forbidden, and there is no opting out of paying taxes for the public system.[3] This combination of stable financing and prohibition of for-profit coverage for medically necessary services significantly reduces the need for bureaucratic controls, excessive record keeping, and the regular renegotiation and constant surveillance of contracts, and it permits the development of systematic coverage in equitable ways.
- **Universality**: Everyone is covered, which is not only more democratic but also cheaper and more efficient. The 1964 Hall royal commission[4] that led to the creation of medicare rejected a two tier system with means testing for eligibility on the grounds that up to three quarters of the population would be eligible for subsidy, depending on the income cutoff thresholds, and the administrative costs of a programme would outweigh the benefits.[1]
- **Accessibility**: Health services must be provided under uniform terms and conditions; this explicitly forbids a two tiered system, user fees, or other means of providing differential or preferred access or different facilities linked to different payment needs. The Hall royal commission rejected differential treatment primarily on the "pragmatic tests of administrative and financial feasibility,"[1] but Canadians have also come to value this principle because it is more equitable and more effective to base access on need rather than on ability to pay.

  The act also includes "reasonable compensation for all ensured services."[2] It recognises that decent pay is essential for those providing services in order to ensure not only quality and stability but also fairness. Only doctors and dentists are mentioned specifically in the list of individual providers, but the act refers to reasonable compensation for hospitals and those hospital services include the services of all who work there.
- **Comprehensiveness**: Although the act does not extend much beyond medically necessary services provided by doctors and hospitals, it does include all services required within these confines. The rationale is simple: to do otherwise would limit access, increase administrative costs, and define care too narrowly in light of what is known about the determinants of health.

the provinces. By 1977, it had unilaterally started to cap its transfer payments to provinces and to shift the form of its support from cash to the creation of tax space for provinces. In 1995, it eliminated the specific health transfer altogether, collapsing federal funding for health, post-secondary education, and social assistance into the new Canada Health and Social Transfer and dramatically reducing its cash transfers. As a result, it is no longer possible to determine the exact federal contribution to healthcare funding.

In addition to the pressure that reduced federal funding places on individuals and on provinces, the new funding method has two important consequences for democracy. Firstly, by concealing the size of its cash transfers for health care, the federal government makes it more difficult for the electorate to hold it to account. Secondly, by reducing its transfers, the federal government reduces its capacity to enforce the popular five principles. For their part, cash strapped provincial governments resist being told how to spend their money by a federal government that is no longer making a clear, large contribution to health care.

The provinces have responded to the federal cutbacks by reducing hospital budgets significantly. This was initially done by reductions to global budgets, leaving hospitals with considerable control. More recent cuts, and a new emphasis on managerial directives based on formulas for costs and care, have altered this balance of power. Provinces have started to close hospitals, and to place them under the control of newly established regional boards. The specific nature and form of this devolution varies from province to province, but all regional boards have budgets determined by the province; at least some of their members are provincially appointed; and hospitals are often severely restricted by provincial directives. These changes have been largely informed by management theory taken from the for-profit sector, without evidence of its applicability to a public health system. Similarly, devolution to regional boards has proceeded with little assessment of its consequences for either democracy or access.

Provinces have also responded to federal reductions by removing public funding from some services, by failing to cover new treatments and services, and by offloading responsibility for some services to municipalities and to private providers. What provinces have not done is seriously challenge the fee for service payment scheme that covers most doctors. Their associations negotiate fee schedules with provincial governments, and doctors then simply send in their bills. Strategies to bring doctors' billing under control have had limited impact. When fees are frozen, doctors bill for more, and for more expensive, services. When a

Health spending, unemployment, and health statistics, Canada and provinces. Data are for 1996 unless indicated otherwise

	Total healthcare spending			Health indicator		
Province	$C per capita	% of GDP	Average annual unemployment rate*	Life expectancy at birth (1995)	Infant mortality per 1000 live births (1995)	Cancer deaths per 100 000 population
All Canada	2500	9.5	9.7	78.3	6.1	184.5
Newfoundland	2300	13.6	19.4	77.3	7.9	189.3
Prince Edward Island	2400	12.3	14.5	77.7	4.6	206.7
Nova Scotia	2300	11.4	12.6	77.9	4.9	209.8
New Brunswick	2400	11.8	11.7	77.8	4.8	192.6
Quebec	2300	9.8	11.8	78.0	5.5	202.6
Ontario	2600	9.1	9.1	78.5	6.0	179.6
Manitoba	2700	11.4	7.5	77.7	7.6	184.6
Saskatchewan	2500	9.8	6.6	78.2	9.1	171.6
Alberta	2300	7.4	7.0	78.6	7.0	173.9
British Columbia	2700	10.0	8.9	79.0	6.0	166.3

GDP=gross domestic product. *% of labour force (aged 15 and over).

cap on overall or individual billing fees is negotiated, it is not respected and costs continue to rise.

Some doctors now work in group practices that are owned and managed by private, for-profit corporations. Many of these practices are walk-in clinics that are open for long hours and serve patients on a casual basis. It is difficult to determine what this development means for individual doctors' choices and rewards or what it means for patients in terms of care. The impact on democracy is clearer, as corporate ownership necessarily entails a loss of public control.

Although doctors in independent private practice remain relatively autonomous and free to bill for whatever services they deem medically necessary, reforms in other areas of the public system are limiting both their choices and their alternatives.

Comprehensive care

The Hall royal commission recommended that the medicare system cover the prescription drug services, optical services, prosthetic services, and home care services to ensure that all necessary care was covered, and covered at the most appropriate level.[4] But the Canada Health Act does not go this far. As well, it specifically excludes nursing homes, residential care services, and institutions for mentally ill people. Although services must be comprehensive as long as they are provided in a hospital or are defined as medically necessary and provided by a doctor, the act fails to cover the full range of care needs and thus restricts access.

Access is threatened by recent changes that restrict hospitals to providing only the most acute care and that restrict what is deemed medically necessary care by doctors outside hospitals. The number of hospital beds declined by 20% between 1986-7 and 1995-6, while the overall population grew by 13% and the population aged 65 and over grew by 30%.[6] People discharged from hospital have not readily found spaces in residential care, given that the number of beds in facilities for elderly people, people with learning disabilities, emotionally disturbed children, and people with addictions actually declined by 1.5% between 1986-7 and 1993-4.[7]

The further care is moved from hospitals and doctors, the further it is moved out from under the umbrella of the Canada Health Act. Although all provinces provide considerable support to long term care facilities and for home care, user fees are usually charged and the care is much more likely to be provided by for-profit firms. The impact is clearly reflected in the share of health care paid for privately, which rose from 23.3% in 1983 to an estimated 30.3% in 1998.[8]

Under devolution, much of the responsibility for rationing care has been downloaded to regional boards. In Ontario, for example, the government has created Community Care Access Centres to provide the sole entry point for publicly funded, long term care and home care services. Governed by boards that are partly appointed and partly elected, these centres face limited budgets and detailed instructions from the province as they try to deal with the many acutely ill patients discharged from hospital, frail elderly people, disabled people and others who have long depended on some form of public care.

For-profit care

Given the limitations of federal and provincial legislation, deinstitutionalisation has profound consequences for both access and control. Although the Canada Health Act requires public administration of health insurance, it remains silent about who the providers must be. When hospital insurance was introduced, the overwhelming majority of hospitals were non-profit, and they have remained so under medicare, although most provinces have no legislation on the issue. For-profit ownership is much more common in residential care, where a third of the facilities are owned by profit seeking firms, many of them large corporate chains.[9] Moreover, until recently most home care was provided either by public employees or by non-profit organisations.

The absence of legislation forbidding for-profit care is particularly problematic under the North American Free Trade Agreement. Although this agreement does provide some protection for the Canadian public health system, it also makes it very difficult to reverse the privatisation process once it has taken place in any Canadian jurisdiction. With health care among the most profitable investment fields in the United States, US firms have looked on Canadian care as "an unopened oyster" ripe for development.[10] And they are being encouraged by some provincial governments. Ontario's Community Care Access Centres, for example, are required to establish competitive bidding mechanisms for the services they fund, and they are prevented from awarding all the contracts to the established non-profit provider, ensuring that for-profit firms (often based in the United States) will be introduced, whatever their quality and price. Across the country, hospitals and regional boards are contracting out services to for-profit firms. "Partnerships" between governments and for-profit organisations have become common. For-profit organisations have been hired to manage care facilities and non-profit organisations have had to adopt for-profit managerial techniques. A few new for-profit hospitals are being established.

These moves to for-profit care have profound consequences for access, equity, and democracy. Public funds are increasingly going to profit rather than to care, as important decisions about publicly subsidised care are increasingly made outside of public view and even outside the country. User fees are rising, shifting the burden of payment to individuals in ways that limit access.

Evidence based everything

The National Forum on Health argued for "more high-quality evidence at the level of both policy and practice; that would make decision making more accountable and produce the best possible health and outcomes."[3] The federal government has enthusiastically embraced this approach, in terms of both policy and funding. Clearly, evidence is critical at all levels of health decision making, but important risks are attached to this new emphasis on data as the basis for decision making.

Firstly, this evidence may be used to undermine democratic processes and professional judgments. Experts in data and accounting methods, rather than health professionals and citizens, may determine choices and do so in ways that are incomprehensible to

most of the electorate. Secondly, the evidence may be used to develop formulas for care that ignore context, eliminate choice, and provide a basis for denying care. Canadian decision makers are already purchasing software programs from American firms that set out such things as critical care pathways, ratios of population to beds, and outcome measures. These programs leave little room for individual or even collective judgments, the characteristics of individual patients, and value choices.

Conclusion

The new public paradigm in Canada is a business paradigm, even within a health system funded by taxes. Not surprisingly then, healthcare reform has focused on management practices adopted from the business world. Much of the downsizing, devolution, amalgamation, and deinstitutionalisation has been done on the basis of untested management theory, although it has been carried out in the name of evidence based decision making. Although there is as yet little evidence on the consequences for patients, providers, and citizens, what evidence there is suggests that quality, choice, and access are declining while individual costs are rising, and more of the decisions are made outside the democratic process and even outside the country.

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Devolving health services to Spain's autonomous regions

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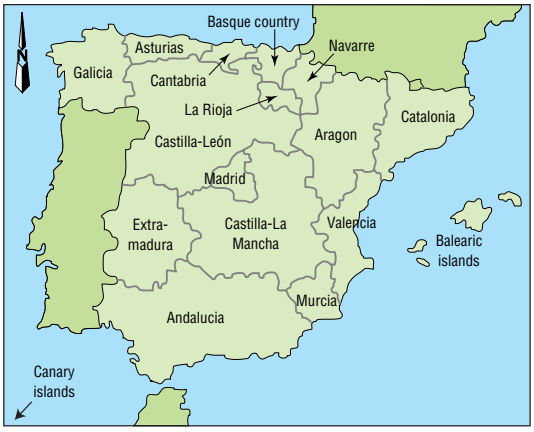
The 1978 Spanish constitution laid down the rights of all Spaniards to health and to health care. It also established regional governments and a process of profound political decentralisation. Seventeen autonomous regions were formed, with sizes ranging from 5045 km^2 in La Rioja to 87 500 km^2 in Andalusia, populations ranging from 263 644 in La Rioja to 7 238 459 in Andalusia (1998 census figures), and population density ranging from 21.6/km^2 in Castille-La Mancha to 634 200/km^2 in Madrid. Each region has its own cultural, socioeconomic, and historical identity and some regions (Catalonia, the Basque country, and Galicia) have their own languages.

In 1986 the General Health Service Act established a national health system with 17 autonomous health services. The main principles of the system were universal coverage, public financing through taxation (and, until recently, through social security funds to some extent), integration of existing health service networks, political devolution to the autonomous health services, and a new model of primary care with multidisciplinary teams based in health centres. The act has not yet been implemented fully.



Devolution has been more rapid in some regions than others

Summary points

In 1981, Spain began a process of decentralisation of the management of health services to its 17 autonomous regions; by 1995 seven autonomous regions (covering 62% of the population) had taken over health care provision

Although devolution may bring control of health services closer to the people who use them, it can lead to differing health policies between regions

Methods used to allocate resources for health services have not yet improved, so inequalities in resource allocation between regions continue

Devolution can also lead to an increase in bureaucracy, with duplication of administration at central and regional levels

National health policies and the concept of a national health service must not be infringed, and existing inequalities on the provision of services must continue to be addressed